State Work Plan for Access Improvement

and

Timeline for Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business

CalAIM 1915(b) Waiver, STCs A1 and A9

Purpose

The California Department of Health Care Services (DHCS) submits this State Work Plan for Access Improvement and Timeline for Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business in response to requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in the Section 1915(b) California Advancing & Innovating Medi-Cal (CalAIM) waiver Special Terms and Conditions (STC) A1 and A9. DHCS is charged with developing a work plan to strengthen monitoring and oversight of plans to improve member access to care for Medi-Cal Managed Care (MCMC), Dental Managed Care (Dental MC), Specialty Mental Health Services (SMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS) by October 7, 2022 (deadline extension approved by CMS). This work satisfies the following requirements within STC A1:

- Detail how DHCS intends to strengthen monitoring and oversight of managed care plans in order to improve beneficiary access to care;
- Identify the data the State must collect and rely on in its efforts to improve beneficiary access to care;
- Explain why this data will assist the State in improving access; and
- Propose measures for assessing access, to be agreed upon by CMS.

In this work plan, DHCS also proposes to CMS a timeline (meeting the requirements of STC A9) for the Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business (STC A8), and proposes a new deadline of December 18, 2026 for the Access Improvement Results Report (STC A2). In addition, DHCS identifies the data DHCS must collect as part of the independent access assessments.

The efforts described in this work plan will be coordinated with and complement other DHCS access policy and monitoring efforts related to network adequacy, telehealth, and appeals and grievances.

Background

CalAIM is a long-term commitment by DHCS to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The CalAIM 1915(b) waiver memorializes the strong commitment between California and CMS to maximize CalAIM's focus on expanding access while also improving monitoring and oversight that will result in increased accountability, improved data collection and analysis, and greater transparency into network adequacy and timely access within and across managed care delivery systems.

Overview of DHCS' Current State Network Adequacy, Timely Access, and Member Experience Monitoring

Network Adequacy: DHCS annually conducts a network certification for all MCMC Plans, Dental MC Plans, SMHS Plans, and DMC-ODS Plans (collectively referred to as "Plans") to ensure each Plan has the capacity to meet necessary covered services for current and anticipated membership, including geographic access standards, provider to member ratios, mandatory provider types, and timely access. All four managed care delivery systems in California also collect data to monitor the adequacy of the provider network, as specified under 42 CFR 438.207(d) . DHCS is moving to a single standard for plans to submit network and program data to DHCS on a monthly basis using the provider network file (274). This is currently the process used by MCMCs and Dental MC Plans. SMHS and DMC-ODS Plans will be moving to this standard in the upcoming years as described in detail in Table 1 below.

Timely Access: DHCS currently collects data from all managed care plans that enables it to identify providers who are accepting new patients. For MCMC and Dental MC, this is accomplished through the provider network file (274). SMHS and DMC-ODS have alternate systems of monitoring but will be moving to this standard in upcoming years. In addition, DHCS also conducts further activities to validate this data including External Quality Review Organization (EQRO) Timely Access Surveys (e.g. secret shopper calls) which assess whether providers are accepting new patients and the providers' next available appointment. These are then compared to plan reported data as well as measured against state Timely Access Standard requirements.

While this activity is currently only performed for MCMC Plans, DHCS is in the process of unifying its three disparate EQRO contracts into a single, standard EQRO approach and will be scaling this practice across all managed care delivery systems through a unified contract. Until then, DHCS intends to conduct a more limited scope secret shopper process in 2025 for DMC-ODS and SMHS providers. Additional details on current activities by delivery system are summarized in Table 1, below.

Member Experience: Across all managed care delivery systems, beyond provider and facility information, DHCS collects data related to member experience, through both standardized member experience surveys, as well as additional member information pertaining to grievances, appeals, and continuity of care requests. DHCS is working to standardize the methods by which this information is collected, as well as the frequency with which reports are reviewed. Current differences by delivery system are summarized below in Table 1.

Pursuant to STC 10c, DHCS will ensure that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey or similar consumer satisfaction survey is conducted annually for beneficiaries enrolled in MCMC, Dental MC, SMHS, and the DMC-ODS programs starting in 2023. In MCMC and Dental MC, DHCS uses CAHPS surveys to track consumer perception of access to care. Beginning in 2023, the CAHPS survey will be conducted annually for MCMC by DHCS and by 2026, MCMC plans are required to administer the CAHPS survey directly, in alignment with National Committee for Quality Assurance (NCQA) accreditation requirements. Dental MC plans already have CAHPS survey requirements compliant with STC 10c. In SMHS, the Consumer Perception Survey, done twice yearly, is used for the same purpose, and the Treatment Perception Survey is used in DMC-ODS. Additional information on all specific data points currently collected can be found in Appendix 1.

Table 1: Differences in Current State Access Monitoring by Managed Care Delivery System

Access Component	Delivery System	Current Approaches	Planned Approaches
Network Adequacy Monitoring	MCP	• Submit monthly provider network file (274)	n/a
	Dental MC	• Submit monthly provider network file (274)	n/a
	SMHS	• Submit annual network adequacy and certification tool (NACT) and Timely Access Data Tool (TADT)	Begin transition to monthly provider network file (274) by 2022-2023, with completion by 2023-2024
	DMC-ODS	• Submit annual network adequacy and certification tool (NACT) and Timely Access Data Tool (TADT)	Transition to monthly provider network file (274) by 2023-2024
Timely Access	MCP	• Analyzes monthly 274 file to monitor who is accepting new patients • EQRO conducts secret shopper calls to verify access • Quarterly comparison report to MCPs	n/a
	Dental MC	• Track all providers from 274 file not accepting new patients • Plan submission of quarterly Timely Access Specialty Referral Report (to monitor ratios dentists to members) • Secret shopper calls to verify accuracy of information	n/a
	SMHS	• Analyzes data from TADT	Will begin 274 monitoring process by 2023-2024 in addition to TADT Will begin secret shopper calls in 2025
	DMC-ODS	• Analyzes data from TADT (implemented 7/1/2022)	Will begin 274 monitoring process by 2023-2024 in addition to TADT Plans to be held accountable to TADT requirements in July 2023 Will begin secret shopper calls in 2025
Member Experience	MCP	• Annual CAHPs survey beginning in 2023 • Quarterly review of grievances, appeals and out of network data • Review of plan-level state fair hearing data to monitor emerging access issues	n/a

	Dental MC	• Annual CAHPs survey	Expand existing MCMC state fair hearing data review process to Dental MC in 2023-2024
	SMHS	• Consumer Perception Survey done every 6 months • Annual review of grievances, appeals and continuity of care data	Transition to quarterly review of grievances and appeals in 2023-2024
	DMC-ODS	• Treatment Perception Survey done every 6 months • Annual review of grievances and appeals data	Annual review of continuity of care data beginning in July 2023 Transition to quarterly review of grievances and appeals in 2023-2024

How Data Collected Today Assist DHCS in Improving Access

DHCS utilizes the annual network certification process in all managed care delivery systems to monitor and improve networks and access in various ways: looking for network improvement through reviewing alternative access standards, assessing that the network has mandatory providers and if it does not, continually working with the Plans and having a mechanism to hold Plans accountable through enforcement actions, including corrective action plans (CAPs) or sanctions.

As described in the previous section, DHCS leverages the 274 provider network file submissions and the Timely Access Survey/Timely Access Data Tool to continually engage with plans multiple times a year on their data quality, compliance with timely access standards and provider directory components through the routine monitoring process (quarterly for MCMC and MC Dental and annually for SMHS and DMC-ODS until they transition to the 274 file submission process). DHCS provides plans with their Timely Access Survey results so they can promptly remediate their findings, and inquiries about Plan actions to resolve findings. Plans that are non-compliant at the end of the year are subject to corrective action, including potential monetary sanctions for non-compliance with Timely Access standards. These processes will be standardized across SMHS and DMC-ODS by 2023-2024 with the transition to the use of monthly reporting via the 274 provider network file and aligned sanctions policy across all delivery systems.

DHCS also analyses grievance and appeal, member complaints and notifies plans of concerns, requests the plan determine the root cause, and asks the plan to report any barriers or challenges with improving performance. If there is a specific medical group and/or provider that is responsible for a large portion of grievances, DHCS asks the plan what mechanism the Plan has in place to support and/or penalize the medical group or provider. In addition, for MCMC plans, DHCS uses complaints data from DMHC and independent medical review complaints, as well as State Fair Appeals/Hearings from the Department of Social Services as a cross-reference to its own grievances and appeals data to determine if there are systemic issues at

the Plan level. Where there are potential issues, DHCS may conduct an ad hoc survey of MCPs to identify potential options and levers to address the root cause of those access concerns.

Plans found deficient in their provider networks are required to submit CAPs detailing how they will increase their provider networks. Plans placed on a CAP must ensure they continue meeting member needs through out-of-network providers and are meeting timely access to services. DHCS monitors the CAPs and the Plans' efforts by collecting and analyzing data and documentation. These network adequacy requirements and processes are aligned across all our managed care delivery systems and are used to identify potential gaps in a Plan's ability to serve all of its members. Moreover, in August 2022 DHCS implemented a sanctions policy that is aligned across our managed care delivery systems regarding our approach, guiding principles, and criteria for enforcing federal/state and contractual requirements enumerated in State statute. DHCS issued guidance to Plans in all our managed care delivery systems regarding this aligned sanctions policy (Behavioral Health Information Notice 22-045 – Enforcement Actions: Administrative and Monetary Sanctions and Contract Termination, All Plan Letter 22-015, and Dental All Plan Letter 22-009). Good cause for imposing administrative and/or monetary sanctions include but are not limited to, failure to meet network adequacy, quality metrics, data quality, and contractual obligations.

How DHCS Intends to Strengthen Monitoring and Oversight of Managed Care Plans to Improve Beneficiary Access to Care

CalAIM's vision to make Medi-Cal a more consistent and seamless system for enrollees to navigate necessitates strengthening monitoring and oversight of managed care plans, especially around access to care. As outlined above, DHCS has made significant strides to standardize and align its approach to managed care plan oversight across all delivery systems, and intends to have consistent processes in place by 2023-2024 with the transition to consistent reporting.

Beyond this administrative consistency across delivery systems, DHCS has also identified a number of key areas of focus to strengthen oversight of its managed care plans. DHCS recognizes that due to complex sub-delegated arrangements with some health plans, strengthened monitoring of sub-delegates is also required and is taking steps to address this across all managed care delivery systems. DHCS will begin reporting on the annual network certification components noted in Appendix 1 for all MCP sub-contractors in addition to MCPs in accordance with the 1915(b) Special Terms and Conditions (STCs) using the CMS-issued template, the Network Adequacy Assurance Tool. This will assist DHCS in analyzing network gaps for members that are not captured in the MCP annual network certification. DHCS will also look to stratify the Timely Access results for MCPs by subcontractor and consider revising measures based on the results of data gathered, beginning with MCMC plans in 2023. Additionally, DHCS is working on policy guidance for the MCPs outlining their obligation to be ultimately responsible for access regardless of the subcontractor to which members are assigned, including ensuring referral pathways and access to services that may not be offered in subcontractor networks. This enhanced monitoring of sub-contractors will go into effect starting in June 2023 for MCMC plans (and sub-delegates) and no sooner than June 2025 for all SMHS and DMC-ODS, and Dental MC plans (and sub-delegates).

In addition, DHCS recognizes additional barriers to access that members face when transitioning between levels of care or seeking follow up appointments after discharge, especially when these activities need to be coordinated across managed care delivery systems. DHCS intends to leverage data exchange and advanced data analytics to more effectively monitor access during these periods of transition. Building upon the California Data Exchange Framework and DHCS' Population Health Management Strategy and Roadmap, DHCS envisions plans leveraging real-time data, including admission, discharge and transfer (ADT) notifications across delivery systems to improve timely transition of levels of care between plans. Starting in January 2023, DHCS will be requiring the use of real-time data feeds for all MCMC plans as a part of the CalAIM Population Health Management Program and new Transitional Care Management requirements. In addition effective July 2024, DHCS will also begin requiring SMHS and DMC-ODS plans to report regularly on timely access for non-urgent follow-up appointments for mental health care or Substance Use Disorder (SUD) treatment; timely transition between levels of care (step-up and step-down); and timely access to treatment services from initial appointment through discharge. DHCS will use the data to strengthen monitoring and oversight of MCPs to improve access to care by ensuring plans continue to provide timely access to care for beneficiaries including but not limited to transitions between levels of care.

As a part of its commitment to achieving health equity, DHCS will also be working to strengthen collection of demographic information, including, but not limited to, race, ethnicity, sexual orientation, gender identity, geographic region, and primary language to enable stratification of all data points and identify potential barriers to timely access to care in various sub-populations.

Lastly, as outlined further below, DHCS plans to contract with an independent evaluator to further assess and make recommendations to improve the measurement and monitoring of member access.

Independent Access Assessments

The 1915(b) STCs require four independent access assessment reports: one for MCMSs across multiple lines of business (STC A8), and one each for Dental MC (STC C24), SMHS (STC A6), and DMC-ODS (STC A7) plans. The latter three independent assessment reports are due to CMS on March 30, 2024; the proposed timeline for the first (STC A9) is outlined below. To improve and align access across all four delivery systems, DHCS intends to contract with a single external evaluator to conduct all four access assessments. DHCS intends to issue a Request for Information (RFI) from potential external evaluators in the fall of 2022 and execute a contract with an external evaluator by December 31, 2022. DHCS intends for the contractor to lead a process of access measure data aggregation and trending, access measure vetting, create an internal access monitoring roadmap, and identify areas for standardization in access monitoring and compliance across delivery systems. The contractor will then work with DHCS to standardize access monitoring and compliance processes across delivery systems and will include recommendations in the Independent Access Assessments. Below we outline the preliminary data the state must collect and rely on to improve beneficiary access to care, and how these data will assist the state in improving access. This plan may be modified based on future input received from the external evaluator.

Data elements the state must collect and rely on to improve beneficiary access to care:

DHCS envisions utilizing four categories of data elements to effectively measure member access: Beneficiary data, capacity and availability data, service utilization data (a measure of realized access), and member experience data. The following data elements will be collected for all four Medi-Cal managed care delivery systems, with sources listed, along with additional delivery-system-specific data mentioned below. More details and proposed measures for assessing access can be found in Appendix 2.

- **Beneficiary Data:** demographics, enrollment, and eligibility - Medi-Cal Eligibility Data System (MEDS)
- **Capacity and availability data:** provider and office/practice demographics and delegation arrangements (e.g., panel size, panel restrictions, acceptance of new beneficiaries), appointment availability - Provider Network Report and/or Network Adequacy Certification Tool (NACT); Timely Access Specialty Referral Reports, Managed Care Program Data (MCPD) and Primary Care Provider Assignment; External Quality Review Organization Timely Access Surveys
- **Service utilization data/realized access:** encounters, utilization reports - Management Information System/Decision Support System (MIS/DSS)
- **Member experience data:** State Fair Appeals/Hearings from the Department of Social Services' (DSS) Appeals Case Management System (ACMS); Consumer complaint and IMR data from DMHC; And Health care complaint data from the Center for Data Insights and Innovation (CDII)/Office of the Patient Advocate (OPA). Additional member experience data across payers is available from the California Health Interview Survey (CHIS) and through CAHPS (MCMC and Dental MC), Consumer Perception Survey (SMHS) and Annual Treatment Perception Survey (DMC-ODS) data.

The following data elements will be collected for Medicare Advantage and commercial plans to support the independent access assessment for MCPs across multiple lines of business. Additional information about these data elements and sources can be found in Appendix 2 and Appendix 3.

- **Beneficiary data:** demographics and enrollment – Department of Managed Health Care (DMHC)
- **Capacity and availability data:** provider and office/practice demographics and delegation arrangements (e.g., panel size, panel restrictions, acceptance of new beneficiaries), appointment availability – Some from DMHC and some may need to be collected by the contractor
- **Service utilization data/realized access:** encounters, utilization reports, – Health Care Access and Information (HCAI) Health Care Payments Data Program (HPD), available starting July 2023. Some financial data available from DMHC.
- **Member experience data:** State Fair Hearing and Independent Medical Review (IMR) decisions, grievances, and appeals/complaints, network and timely access standards across lines of business – State Fair Appeals/Hearings available from the DSS' Appeals Case Management System (ACMS). Consumer complaint and IMR data available from DMHC. Health care complaint data available from the Center for Data Insights and

Innovation (CDII)/Office of the Patient Advocate (OPA). Additional member experience data across payers is available from the California Health Interview Survey and through CAHPS data.

The independent network analyses across multiple lines of business will be done to account for geographic differences including provider shortages at the local and state levels, as applicable. HCAI's California Health Workforce Research Data Center has data on health care workforce supply and demand in HCAI's California Primary Care Needs Assessment, which identifies workforce shortage areas in California. These analyses will also account for previously approved alternate network access standards, access to in-network and out-of-network providers separately, and number of providers accepting new patients.

Why these measure elements will assist the state in improving access:

Having a consistent set of access elements that are tracked across all delivery systems, as well as an independent access evaluation across lines of business will provide essential information to DHCS to better hold MCPs accountable, as well as guide future policy development. The proposed data points for assessing access will enable DHCS to compare network performance across delivery systems as well as across the state in a uniform way; the independent access assessment will allow DHCS to assess potential root causes for access concerns and reveal whether the underlying access concerns are tied to an overall lack of providers versus providers from other business lines not contracting with Medi-Cal plans. The utility of specific data elements is outlined below but will be informed and updated as needed by the external evaluator:

- **Beneficiary Data:** Each local network should be tailored to meet the needs of its members not only based off of expected enrollment and utilization, but also to reflect the local health needs and demographics of the population being served. The data elements described will enable DHCS to better measure access for sub-populations to identify health disparities that may be hidden in aggregate measures of access. In addition, having standard measurement across all delivery systems will enable county-level comparisons across delivery systems to identify outliers and best practices for regions where there are known barriers such as lack of providers or low population density.
- **Capacity and availability of services data:** A comparison of network adequacy standards (including but not limited to provider to member ratios, time and/or distance and timely access standards) across Medi-Cal, Medicare and Commercial lines of business will enable DHCS to identify additional trends in network deficiencies, regional themes, and systemic gaps in access to levels of care or covered services not currently monitored (for example, the availability and extent of prescribers that have obtained the requisite waiver to prescribe buprenorphine in each DMC-ODS plan). In addition, the assessment may allow DHCS to assess potential reasons for access concerns and reveal whether the underlying access concerns are tied to an overall lack of providers. Additional measures of provider-level access, such as secret shopper calls to independently validate plan-reported timely access standards, or real-time measures (such as Third Next Available Appointment) of initial and follow up appointments, will build upon the current data sources that DHCS uses to assess access to care and enable DHCS to better understand how access is truly realized for members.

- **Service utilization data:** DHCS will use data elements around realized access by comparing population-based disparities in penetration/service utilization, enrollee wait times (e.g. third next available appointment), utilization of network (e.g. percent of network that is actually being utilized on a per member basis) and member outcomes to understand whether the contracted network is actually being utilized and is accessible to assigned members or if network providers, despite being contracted and counted in network adequacy, are not addressing member needs and contributing access. In addition, the comparison with member quality outcomes (e.g. well-child visits and dental utilization), will enable an analysis of correlation between realized access and outcomes.
- **Member experience data:** Capturing and using member voices is a critical component of understanding how access is experienced by those seeking services and is also a core pillar of DHCS' Comprehensive Quality Strategy. DHCS intends to strengthen and increase its frequency of member experience surveys across all delivery systems as well as create systems to better use this information to identify trends at the plan and provider level. A comparison of available enrollee concern data including, but not limited to, State Fair Hearing and Independent Medical Review, grievance and appeals/complaints data and member experience survey results will allow for comparisons across Medi-Cal delivery systems, as well as with other lines of business and improved accountability. In addition, understanding member experience at the sub-population level will also enable DHCS to better measure health disparities, especially for marginalized populations who have historically faced discrimination within the healthcare system to ensure that plans are addressing healthcare based discrimination and access for these populations.

Table 2: Work Plan for Access Improvement and Reporting Timelines, including Timeline for Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business (STC A9)

Date	Activity	Description
January 1, 2022 – June 30, 2022	DHCS Internal Assessment	• Analyze STC requirements • Assess approaches and considerations for operationalizing the STC requirements • Gather data on current access measurement across delivery systems and planned access improvement efforts to date

May 1, 2022 – June 30, 2022	Initial CMS Engagement	• Engage CMS to discuss STC A1, A2, and A8 status, timelines, and requirements. • CMS initially approved a revised deadline of September 27, 2022 for A1 and allowed DHCS to propose a revised deadline for submitting A2 and the timeline in A9 as part of the September 27, 2022 A1 submission. CMS later approved a revised deadline of October 7, 2022.
July 1, 2022 and ongoing	DHCS State Work Plan for Access Improvement working group launched	This internal working group is focusing on alignment and standardization of access data, measures, and accountability across delivery systems.
May 1, 2022 – October 7, 2022	Work Plan development	• Draft and revise State Work Plan for Access Improvement (STC A1)
October 7, 2022	Final State Work Plan for Access Improvement (STC A1), and Timeline for Medi-Cal Managed Care Plan Access Report Across Multiple Lines of Business (STC A9) due to CMS	• Revised deadline for submitting A2 proposed in A1 • DHCS and CMS agree on timeline for submission of Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business
August, 2022 – October, 2022	Request for Information (RFI)	DHCS Quality & Population Health Management (QPHM) develops and issues RFI to identify potential external evaluators for STCs A6, A7, A8, and C24.
November, 2022	Evaluate RFI responses	DHCS QPHM decide with whom DHCS should contract for the external evaluations (STCs A6, A7, A8, and C24).
December, 2022 – January 2023	Contract execution	DHCS QPHM executes contract with external evaluator for independent access assessment across all delivery systems (STCs A6, A7, A8, and C24).
February 1, 2023	Independent Access Report for SMHS (STC A6), DMC-ODS (STC A7), and Dental MC (STC C24)	CY 2021 data sent to contractor

February 1, 2023 – March 31, 2023	Access data aggregation and trending	DHCS contractor pulls together all current DHCS access data across four managed care delivery systems from all available sources, and trends the data
March 1, 2023 – April 30, 2023	Access measure development and vetting	DHCS contractor analyzes preliminary data elements and sources proposed in this Work Plan, proposes access measures, works with DHCS to vet with stakeholders, and finalizes measures to be used in both the Access Improvement Results Report (STC A2) and the Independent Access Assessments (STCs A6, A7, A8, and C24).
July 2023	Enrollment, diagnoses, and utilization measure specifications	DHCS contractor analyzes preliminary utilization and program enrollment measures, works with DHCS to vet with stakeholders, and finalizes specifications and measures related to encounter, primary care/specialty care utilization, mental health and substance abuse conditions.
April 1, 2023 – June 30, 2023	Internal access monitoring roadmap	DHCS contractor completes internal access monitoring roadmap to identify areas for standardization in access monitoring across delivery systems
May 2023	Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business (STC A8)	Data source feasibility and procurement process confirmed by contractor
July 2023	HCAI Health Care Payments Data Program (HPD) available	Data on encounters and utilization start being available across all lines of business
July 1, 2023 – June 30, 2024	Access monitoring standardization	DHCS contractor works with DHCS to standardize access monitoring processes across delivery systems
November 2023	Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business (STC A8)	Contractor works to execute legal data sharing agreements with other state entities
January 31, 2024	Draft Independent Access Reports submitted by contractor to DHCS	Contractor submits Independent Access Report for SMHS (STC A6), DMC-ODS (STC A7), and Dental MC (STC C24) to DHCS for program review.
February 1, 2024 – March 29, 2024	Review of Independent Access Reports	Programmatic and executive review of draft Independent Access Reports submitted to DHCS by contractor.

March 30, 2024	Final Independent Access Report for SMHS, DMC-ODS, and Dental MC	Submission of Independent Access Report for SMHS (STC A6), DMC-ODS (STC A7), and Dental MC (STC C24) to CMS.
January 31, 2025	Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business (STC A8)	CY 2023 data sent to contractor
July – December 2025	Draft Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business	DHCS staff review report drafts and contractor incorporates changes
January 1, 2026	Draft Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business submitted by contractor to DHCS	Contractor submits final draft report to DHCS for program and executive review.
January 31, 2026	Access Improvement Results Report (A2)	CY 2022, 2023, 2024 data sent to contractor
February 1, 2026 – March 29, 2026	Review of Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business	Programmatic and executive review of draft report submitted to DHCS by contractor.
March 31, 2026	Final Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business	Submission of final report (STC A8) to CMS.
June – September 2026	Draft Access Improvement Results Report (STC A2)	DHCS staff review report drafts and contractor incorporates changes
September 18, 2026	Draft Access Improvement Results Report (STC A2) submitted by contractor to DHCS	Contractor submits final draft report to DHCS for program and executive review.
September 21, 2026 – December 17, 2026	Review of Access Improvement Results Report (STC A2)	Programmatic and executive review of draft report submitted to DHCS by contractor.
December 18, 2026	Proposed revised submission date for Access Improvement Results Report (STC A2)	Submission of final report (STC A2) to CMS.

Access Improvement Results Reporting (STC A2)

The 1915(b) STCs require that the state submit this report detailing areas with marked improvement, and areas without marked improvement, to CMS 18 months after submission of this work-plan to CMS. However, on the May 9, 2022 1915(b) Kickoff Call between DHCS and CMS, CMS agreed to consider extending the due date for STC A2 due to these challenges. For areas without improvement, the State must make recommendations on actions the State and CMS may take to effectuate clear improvement. The report must include a comparison of the medical loss ratio detailed in STC A11 and the Access Reporting data detailed in STC A4 inclusive of delegated plans within Medi-Cal Managed Care.

As detailed above, DHCS has considerable gaps in access reporting that we have plans to improve. Specifically, DHCS will not start collecting data on DMC-ODS timely access via the Timely Access Data Tool until July 1, 2023, will not have data on timely transition between SMHS and DMC-ODS levels of care until the 2025 Network Adequacy Certification Period, and will not have MCP timely access data stratified by sub-contractor until the 2023 Timely Access

survey. In addition, DHCS intends to further internally map and standardize approaches to access monitoring across managed care delivery systems, which will take time to effectuate. In addition, the calendar year 2022 MLRs will not be finalized and submitted to CMS until Quarter 3, 2024. Because of these timing issues, DHCS proposes submitting to CMS the Access Improvement Results Reporting deliverable A2 on December 18, 2026 to be able to include these important access data elements, including the MLR data detailed in STC A11 and the Access Reporting data detailed in STC A4 inclusive of delegated plans within Medi-Cal Managed Care. This deadline extension will give DHCS the opportunity to include in the Access Improvement Results Report (A2) data from services provided in CY 2022, 2023, and 2024, which will not be available until January, 2026.

Appendix 1: Detailed Network Adequacy, Timely Access, and Member Experience Data Collected Today

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
Provider network file data collection tool and frequency	Provider network file (274), submitted to DHCS monthly	Provider network file (274), submitted to DHCS monthly	Network Adequacy Certification Tool (NACT), and other systems on an annual basis	NACT and other systems on an annual basis
Data collected in provider network file	Provider geographic and demographic info Prime MCP and subcontractor evaluation Provider specialty type Provider's site info (physical accessibility, languages spoken, etc.) Member assignment, if PCP or general practice dentist Whether or not accepting new patients	Provider geographic and demographic info Prime MCP and subcontractor evaluation Provider specialty type Provider's site info (physical accessibility, languages spoken, etc.) Member assignment, if PCP or general practice dentist Whether or not accepting new patients	Provider geographic and demographic info SMHS and subcontractor affiliation Provider specialty type Provider's site information Whether or not accepting new patients Total number of patients provider is capable of serving	Provider geographic and demographic info DMC-ODS and subcontractor affiliation Provider specialty type Provider's site information Whether or not accepting new patients Total number of patients provider is capable of serving
Required provider to member ratios	1 Primary Care Physician: 2,000 Members 1 Physician: 1,200 Members 1 Physician: 4 Non-Physician Medical Practitioners	1 Primary Care Dentist: 2,000 Members 1 network (primary care or specialist) dentist: 1,200 Members	Adult Outpatient SMHS - 1:85 Child Outpatient SMHS - 1:43 Adult Psychiatry - 1:524 Child Psychiatry - 1:323	DHCS collects data on the maximum and current capacity of providers by modality and age via NACT, and compares the data to Plans' expected utilization

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
	Compliance determined annually and assessed quarterly.			
Minimum network adequacy requirements for mandatory provider types	MCP reported data in the 274 provider network file used to assess compliance with provider types in accordance with SHO 16-006: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Care Providers, Freestanding Birthing Centers, Certified Nurse Midwives and Licensed Midwives. DHCS verifies network data with list of facilities in Fee-for-service (FFS) enrolled provider list that meet the facility criteria.	Provider Network Report submitted on a quarterly basis to assess Dental MC Plan compliance with provider types: FQHCs, RHCs, and Indian Health Care Providers.	Demonstration of good-faith effort to contract with Indian Health Care Providers. Current contracts not currently measured. SMHS networks must include at least one (1) Intensive Care Coordination provider and one (1) Intensive Home Based Services.	Demonstration of good-faith effort to contract with Indian Health Care Providers. Current contracts not currently measured.

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
Time or distance standards	Currently using the MCP-provided geographic accessibility maps starting in calendar year 2022 DHCS will run GeoAccess analysis utilizing the MCP's 274, to allow for a more real time assessment.	Data reported on the Provider Network Report by Dental MC Plans. DHCS utilizes Geographic Information Systems (GIS) software to validate and evaluate the geographic distribution of the Dental MC provider networks for children and adults.	Data reported on the NACT, and the most current Medi-Cal Eligible Data System data. Analysis includes plotting time and distance for all network providers, stratified by provider type and age group of Medi-Cal beneficiaries that reside in each county.	Data reported on the NACT, and the most current Medi-Cal Eligible Data System data. Analysis includes plotting time and distance for all network providers, stratified by provider type and age group of Medi-Cal beneficiaries that reside in each county.
Alternative Access Standards/Telehealth	MCPs submit alternative access requests by service area/ZIP code if they are unable to meet time or distance standards. Telehealth may be used in certain circumstances to meet time or distance standards, provided that the alternative access requests demonstrate that the telehealth provider is providing additive access and not merely substituting for in-person visits.	MCPs submit alternative access requests by service area/ZIP code if they are unable to meet time or distance standards. Telehealth may be used in limited circumstances to meet time or distance standards, provided that the alternative access requests demonstrate that the telehealth provider is providing additive access and not merely substituting for in-person visits.	SMHS Plans submit alternative access requests by service type and ZIP code if they are unable to meet time or distance standards. Telehealth may be used in certain circumstances to meet time or distance standards, provided that the alternative access requests demonstrate that the telehealth provider is providing additive access and not merely substituting for in-person visits.	DMC-ODS Plans submit alternative access requests by service type and ZIP code if they are unable to meet time or distance standards. Telehealth may be used in certain circumstances to meet time or distance standards, provided that the alternative access requests demonstrate that the telehealth provider is providing additive access and not merely substituting for in-person visits.

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
Data tool to assess compliance with language assistance capabilities	For MCP call centers and providers, Timely Access Survey	Quarterly Linguistic Services Report	DHCS staff analyze language assistance contracts and/or invoices for each SMHS Plan	DHCS staff analyze language assistance contracts and/or invoices for each DMC-ODS Plan
Transition of care	MCPs must share data regarding transitioning beneficiaries from one MCP to another. If a member transitions, DHCS shares 12 months of historical encounter data. If a member is forced to transition (i.e., if the member's current MCP exits the market), then the member can request that the MCP to which the member will transition provide continuity of care for their current providers and services.	Plans must share historical utilization data for members transferring between FFS and Dental MC, and between Dental MC Plans. All Dental MC members with pre-existing provider relationships must be given the option to continue treatment of up to 12 months with an out-of-network Medi-Cal FFS provider or a provider accessed through another Dental MC Plan.	Transition of Care/Continuity of Care is required of SMHS Plans and is stated in the Plan contracts and Behavioral Health Information Notices (BHINs). DHCS requires SMHS Plans to report requests for transition of care received and the status of the request.	

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
Provider directory	Members receive instructions on how to request or access the Provider Director in the Member Handbook. MCPs required to post on their web site an updated Provider Directory monthly. DHCS conducts a biannual desk audit and makes verification calls to determine compliance. Starting in 2022, DHCS incorporated verification checks within the Timely Access Survey in order to gather data on provider directory compliance that will be shared with the MCPs.	Dental MC Plans are required to update provider directory monthly and no later than 30 calendar days after the Dental MC Plan receives updated provider information. Beginning in 2022, as part of the annual network certification process, DHCS will conduct secret shopper calls to ensure information contained within the Dental MC Plan provider directory is valid.	Plans required to post an updated Provider Directory monthly. DHCS conducts an annual desk review to ensure compliance.	Plans required to post an updated Provider Directory monthly. DHCS conducts an annual desk review to ensure compliance.
Timely Access	**MCMC**	**Dental MC**	**SMHS**	**DMC-ODS**
Is the contracted provider accepting new patients?	DHCS uses reported, assigned, and maximum member counts (required to be reported for PCPs) to identify PCPs who are accepting new patients; EQRO Timely	Provider Network Report to DHCS on a monthly basis provides DHCS with details about each provider within the DMC Plan's network, specifically whether the provider is	BH has instructed Plans to report the maximum number of Medi-Cal Beneficiaries the rendering provider will accept and the current number of Medi-Cal beneficiaries	BH has instructed Plans to report the maximum number of beneficiaries the Site will accept at any given time and the current number beneficiaries assigned

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
	Access Survey to confirm with calls: % of providers with "Accepting New Patient" status in the MCP's network provider file (274) confirmed by calls, % of providers accepting new patients based on the call alone and not taking into account what is in the provider file, measures to assess degree of contracting with available providers.	accepting new patients.	assigned to the provider.BH plans to take new steps to validate the provider network data submitted by BH Plans.	to the site. BH plans to take new steps to validate the provider network data submitted by BH Plans.
How long are members waiting to see a provider	Timely Access Survey (done by EQRO) used to capture appointment availability and measure the accuracy of the Plan submitted network provider file (274. Performed annually, on a random sample of providers. Includes: Timely Access standard compliance for providers, MCP call centers and MCP nurse advice triage lines, provider file	Quarterly Timely Access Specialty Referral Report from DMC Plans provides data on the average amount of time for members to obtain an initial Primary Care Dentist appointment, routine appointment, specialist appointment/referral, emergency appointment, and percentage of "no	Data reported includes date of first request for services, first appointment offered date, whether or not the appointment occurred, and closeout reason. Data is reported by provider type and beneficiary age group.	Data reported includes date of first request for services, first appointment offered date, whether or not appointment occurred, and closeout reason. Data is reported by provider type and beneficiary age group.

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
	(274) data quality (e.g. provider information, contract status), Provider Directory compliance (e.g. Physical Accessibility, accepting new patients indicator), other access issues including but not limited to long hold times to set up appointment, incorrect phone numbers; and awareness of the language rights afforded to members.	show" appointments. DHCS secret shopper calls on a random sample of providers within each Plan used to assess if providers are meeting required appointment timeframes.		
Timely Access Standards	Quarterly monitoring process assessing compliance with timely access standards: Provider Office Wait Time is measured by assessing the percentage of calls meeting the provider specific wait time standard for urgent and non-urgent appointments; MCP Call Center Wait Times is measured by assessing the percentage of calls	Initial appointments within four weeks, routine appointments (non-emergency) within 4 weeks, preventive dental care within 4 weeks, specialist appointments for adults within 30 business days from authorized request, specialist appointments for children within 30 calendar days from authorized request,	Outpatient Non-Urgent, Non-Psychiatric Specialty Mental Health Services: offered an appointment within 10 business days of request for services. Psychiatric Appointment Request: Urgent: 48 hours w/o prior authorization 96 hours w/ prior authorization Non-urgent: offered an appointment within	Outpatient & Residential Services – SUD: IOT, & Outpatient Treatment (formally known as ODF): Offered an appointment within 10 business days of request for services Opioid Treatment Program: Within 3 business days of request.

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
	meeting the wait time standard of 10 minutes; MCP Nurse Advice Triage Line Wait Times is measured by assessing the percentage of calls meeting the nurse advice line wait time standard of 30 minutes.	and emergency appointments within 24-hours.	15 business days of request for services	
Member Experience of Access	**MCMC**	**Dental MC**	**SMHS**	**DMC-ODS**
Grievances and appeals	Assessed quarterly using MCP reported data in the Managed Care Program Data set to assess for access to care issues for the following categories: Transportation; Provider Availability; Geographic Access; Timely Access; Language Access; Physical Access and Continuity of Care.	Quarterly grievance and appeals report from each Plan identify access related grievances and appeals submitted to the Plan by the member/authorized representative.	DHCS collects grievances and appeals related to: Services not available, Services not accessible, Timeliness of services, 24/7 Toll-free access line, Linguistic services, Other access issues, Authorization delay notices, and/or Timely access notices.	DHCS collects grievances and appeals related to: Access to care, Availability of services, Accessibility of services, and/or Timeliness of services.

Network Adequacy	MCMC	Dental MC	SMHS	DMC-ODS
Member complaints and independent medical reviews	Provided to DHCS by DMHC quarterly. Once DHCS can identify specific complaint types, DHCS Ombudsman will flag any systemic issues (or spikes in complaints) identified by Plan to the proper DHCS oversight areas for further investigation. DHCS tracks complaints as one of the call reasons. The Ombudsman has the ability to run reports but due to system limitations only the count of complaints is available at this time and the Ombudsman report does not currently report complaint data.	Provided to DHCS by DMHC quarterly. Once DHCS can identify specific complaint types, MDSD will flag any systemic issues (or spikes in complaints) identified by Plan to the proper DHCS oversight areas for further investigation and resolution. Quarterly grievance and appeals report from each Plan identifies access related grievances and appeals submitted to the Plan by the member/authorized representative.	DHCS collects quantitative data on grievances and appeals via the Managed Care Program Annual Report (MCPAR). Complaint resolution is delegated to the MHP.	DHCS collects quantitative data on grievances and appeals via MCPAR. Complaint resolution is delegated to the DMC-ODS Plan.
Member surveys	Annual CAHPS survey	Annual dental CAHPS survey	Consumer Perception Survey, done twice yearly	Annual Treatment Perception Survey

Appendix 2: Independent Access Assessments: Proposed Data Elements and Data Sources to be Used for Developing Measures for Assessing Access

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
Beneficiary Data	Beneficiary demographics (i.e., age, sex, comorbidities, language, race/ethnicity, zip code) and enrollment trends	Source: Enrollment Data	Source: Enrollment Data	Source: Enrollment Data	Source: Enrollment Data	Potential sources of beneficiary data: HCAI Health Care Payments Data Program (HPD) and DMHC. Data source feasibility and procurement process to be confirmed by contractor by April, 2023.
	Number of unique enrollees in a plan as of the first of the month for the measurement period, by plan, by geography service type, and/or line of business, as applicable	Source: Enrollment Data	Source: Enrollment Data	Source: Enrollment Data	Source: Enrollment Data	
	Percentage of enrollees whose addresses fall within pre-specified time/distance standards for primary/specialty providers or average distance to providers, by plan, service type, and/or line of business, as applicable	Source: Enrollment Data; Provider Network Data	Source: Enrollment Data; Provider Network Data	Source: Enrollment Data; Provider Network Data	Source: Enrollment Data; Provider Network Data	

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
	Unique, active* providers licensed in the State of California as of January 1, 2023, that are contracted with one or more plans by line of business to be stratified by provider specialty, network status, geography, healthy places index, and/or American Society of Addiction Medicine (ASAM) level of care and enrollment trends.	Source: Healthcare Provider Information (EDI 274)	Source: Healthcare Provider Information (EDI 274)	Source: Healthcare Provider Information (EDI 274 or comparable data)	Source: Healthcare Provider Information (EDI 274 or comparable data)	
Capacity and Availability	Percent of contracted network providers with claims in the last 12 months, stratified by primary care, specialty type, and behavioral health, and/or service type, and/or American Society of Addiction Medicine (ASAM), level of care, as applicable	Source: Provider Network Data; Claims and Encounter Data	Source: Provider Network Data; Claims and Encounter Data	Source: Provider Network Data; Claims and Encounter Data	Source: Provider Network Data; Claims and Encounter Data	Potential sources of provider data: HCAI workforce data, state licensure boards, and DMHC. Data source feasibility and procurement process to be confirmed by contractor by April 2023.

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
	Provider and office/practice demographics (including service geographic location and provider race/ethnicity)	Source: Provider Network Data	Source: Provider Network Data	Source: Provider Network Data	Source: Provider Network Data	
	Average number of days to third next available appointments for new and return members by plan and by provider type.	Source: Timely Access Study	Source: Timely Access and Specialty Referral Report from Dental MC plans	Source: "Secret shopper" calls	Source: "Secret shopper" calls	Potential data sources: DMHC. Data source feasibility and procurement to be confirmed by contractor by April, 2023.
	Track enrollees receiving primary care, specialty care, mental health, and substance use services.	Source: Claims and encounter data	Source: Claims and encounter data	Source: Claims and encounter data	Source: Claims and encounter data	
Service Utilization (Realized Access)	Monitor utilization across categories of service by delivery system for beneficiaries using standardized measures.	Source: Claims and encounter data	Source: Claims and encounter data	Source: Claims and encounter data	Source: Claims and encounter data, National Survey on Drug and Use Health (NSDUH)	Potential sources of encounter/utilization data: HCAI HPD and Utilization/Financial Reports. Data source feasibility and procurement process to be confirmed by contractor by April, 2023.

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
	Percent of beneficiaries with a usual source of care. Includes percent of children/adults with an identified primary care provider, usual source of care for dental, percentage of enrollees with mental health diagnoses with mental health provider, and percent of people in outpatient substance use treatment divided by estimates of prevalence of dependence from SAMHSA's National Survey on Drug Use and Health (NSDUH), by alcohol and separately by other illicit drugs	Source: Plan reported data; Claims and encounter data	Source: Plan reported data; Claims and encounter data	Source: Plan reported data; Claims and encounter data	Source: Plan reported data; Claims and encounter data	
Member Experience	Number of grievances and complaints by grievance/complaint type per month per 1,000 members by plan and by line of business, as applicable	Source: Plan reported data	Source: Plan reported data	Source: Consumer Perception Surveys (CPS)	Source: Treatment Perception Surveys (TPS)	Potential sources of member experience data: California Department of Managed Health Care (DMHC); DSS; Office of Patient Advocate (OPA); Medi-Cal Managed Care and Mental
	Number of State Fair Hearings/Independent Medical Reviews by type per month per 1,000	Source: State Fair Hearings (DSS); Independent	Source: State Fair Hearings (DSS); Independent	N/A	N/A	

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
	member by plan and by line of business, as applicable. Decisions rendered partially, wholly, or adversely for the beneficiary, or if the state fair hearing was retracted by the enrollee or their authorized representative prior to a decision being rendered	Medical Reviews (DMHC)	Medical Reviews (DMHC)			Health Office of the Ombudsman Data source feasibility and procurement process to be confirmed by contractor by April, 2023.
	Provider surveys regarding available languages of provider services and perceptions of patient access	Data source being confirmed	Data source being confirmed	Data source being confirmed	Data source being confirmed	Data source feasibility and procurement process to be confirmed by contractor by April, 2023.
	Network and timely access standards across lines of business	Data source being confirmed	Data source being confirmed	Data source being confirmed	Data source being confirmed	Timely Access Study (Medi-Cal Managed Care); Timely Access Study (contracted survey of DMHC's commercial plans, MediCare, and Medi-Cal data); Consumer Assessment of Healthcare Providers & Systems (CAHPS);

	Data Elements	MCMC	Dental MC	SMHS	DMC-ODS	Medicare Advantage/ Commercial
						California Health Interview Survey (CHIS) (Timely access to care, Usual source of care, and provider/beneficiary perceived language discordance) Data source feasibility and procurement process to be confirmed by contractor by April, 2023.
	Beneficiary experience and feedback via member experience surveys (i.e. timely access to services, time and/or distance to get to services, availability, etc.)	Data source: CAHPS Survey results	Data source: CAHPS Survey results; Annual EQRO Report Findings	No known source (being confirmed)	No known source (being confirmed)	NCQA/CAHPS commercial, Medicare, and Medicaid benchmarks Data source feasibility and procurement process to be confirmed by contractor by April, 2023.
*"Active" providers are those with at least 10 Medi-Cal claims during the relevant year.						

Appendix 3: Background on Non-DHCS data sources

A. HCAI

- HCAI Workforce Data - HCAI's California Health Workforce Research Data Center (Research Data Center) serves as the state's central hub of health workforce data. In addition to the workforce supply, demand, and education data, HCAI uses Health Professional Shortage Area (HPSA) designations published by the Health Resources and Services Administration to identify areas and populations that are experiencing a shortage of health professionals and works with health care providers and stakeholders to maintain existing designations, and to establish new designations where appropriate.

  The discipline-specific methodology identifies: 1) Primary medical HPSA; 2) dental HPSA; and 3) mental health HPSA. Data on population-to-provider ratio, full-time equivalent (FTE), location of designation and other quantitative measures are collected and made available as part of the designation process per Open Data Portal HCAI publications:

  1. Health Professional Shortage Area Primary Care https://data.chhs.ca.gov/dataset/health-professional-shortage-area-primary-care3
  2. Health Professional Shortage Area Dental https://data.chhs.ca.gov/dataset/health-professional-shortage-area-dental3
  3. Health Professional Shortage Area Mental Health https://data.chhs.ca.gov/dataset/health-professional-shortage-area-mental-health3

  When Available: Now

  Possible Metric(s): In combination with managed care annual network certification compliance review, behavioral health and dental MC network capacity requirements, HCAI data can be used to assess statewide provider accessibility and shortage, provide comparative information on beneficiary-provider/FTE ratios, and contextualize provider capacity data, sufficiency, and CAPs. For service areas that don't meet timely access/ distance standards, DHCS can compare proportion of Medi-Cal beneficiaries to the overall California population living in HPSA designated areas to evaluate network adequacy/access in a statewide context.

- HCAI HPD – The HCAI Health Care Payments Data Program (HPD) - The HPD, often referred to as an All-Payer Claims Database or APCD, is being established to collect health care data from health care plans, health insurers, government agencies and others. The HPD will streamline and improve California's ability to monitor health system performance through more complete and standardized data; and enable a better, lower-cost approach to planning and evaluating programs and improvement initiatives. The HPD is intended to support greater health care cost transparency, inform policy decisions supporting quality health care, and to reduce health care costs and disparities.

When Available: The HPD system's database technical infrastructure and initial production of analytic reports is scheduled to be substantially complete by July 2023.

Possible Metric(s): 1) CMS Adult and Child Health Care Quality Measures (including primary and preventive care access measures) by increasing the number of Medicaid members included in the calculations. 2) Access to care metrics for Medi-Cal beneficiaries based on evaluating the full patient load across providers, accounting for both Medi-Cal and Non-Medi-Cal patients. 3) Care coordination metrics for Dual Eligibles that include Medicare utilization data for a holistic examination of care provided to Dual Eligible Medi-Cal members.

- HCAI Health Facility Utilization Reports - All state-licensed hospitals and hospital systems, long-term care facilities, primary care and specialty clinics, home health agencies and hospices report detailed facility-level data on an annual basis. The complete Data Set of annual utilization data reported by facilities varies by facility type. As an example, hospital data contains basic licensing information including bed classifications; patient demographics including occupancy rates, the number of discharges and patient days by bed classification, and the number of live births; as well as information on the type of services provided including the number of surgical operating rooms, number of surgeries performed (both inpatient and outpatient), the number of cardiovascular procedures performed, and licensed emergency medical services provided.

  When Available: Now

  Possible Metric(s): Comparative utilization metrics.

- HCAI Hospital & Long-Term Care (LTC) Facility Financial Reporting - All state-licensed hospital and LTC facilities (skilled nursing, intermediate care, intermediate care/developmentally disabled, and congregate living health facilities) are required to submit an annual Disclosure Report. The report contains detailed financial and utilization information about the facility such as:
  - Type of ownership and inventory of provided services;
  - Number of beds and utilization statistics by payer;
  - Balance sheet and income statement;
  - Revenue by payer and by revenue center;
  - Expenses by natural classification and by cost center; and
  - Productive hours and hourly rates by employee classification and by cost center.

  When Available: Now

  Possible Metric(s): Comparative financial, utilization, staffing metrics.

B. California Department of Public Health (CDPH)

- CDPH Vital Records – Birth Records - Vital Records has a record of all California live births, including items necessary to establish the fact of the birth and medical and social information such as: date of birth, place of birth, birth weight, pregnancy history, race and ethnicity of the mother and any other parent, date of first prenatal care visit, the number of prenatal care visits, and the date of last prenatal care visit, hearing screen results, parental occupation and industry, education level of the mother and father or parent. Additional data includes a description of complications and procedures of pregnancy and concurrent illnesses, congenital malformation, and any complication or procedure of labor and delivery, including surgery, provided that this information is essential medical information and appears in total on the face of the certificate; and principal source of payment for prenatal care and delivery, which includes the following: Medi-Cal, private insurance, self-pay, other sources, and any other categories determined by CDPH.

  When Available: Now

  Possible Metric(s): Comparative birth outcome metrics.

- CDPH California Immunization Registry (CAIR2) - The CAIR2 is a single, consolidated statewide Immunization Information System for vaccinations for vaccine-preventable diseases.

  When Available: Varies by metric.

  Possible Metric(s): Comparative vaccination rates for vaccine preventable diseases.

- California Cancer Registry (CCR) - The CCR is a statewide population-based cancer registry that collects information about almost all cancers diagnosed in California.

  When Available: Now

  Possible Metric(s): Comparative cancer rates and assessment of downstream impacts of lack of or delayed access to care.

C. DSS - State Fair Appeals/Hearings from DSS Appeals Case Management System (ACMS). State Hearings can be requested by people who have applied for, have received, or are currently receiving benefits/services from an DSS assistance program and have received a Notice of Action from a County or a letter from Covered California denying or reducing their benefits, or if they turned in an application or other information and the county or Covered California did not act on it.

   When Available: Now.

D. DMHC - DMHC has data for health plans licensed by the DHMC, including enrollment data, data from consumer complaint and Independent Medical Reviews (IMR) administered by the DMHC, enforcement actions and financial data.

When Available: Varies by metric.
- Complaint/IMR data is available to DHCS now.
- DHCS will leverage DMHC's complaints/IMRs as a data point for the MCMC multipayor access assessment.

Possible Metric(s): DMHC data can be used to evaluate gaps in care, compare commercial, Medicare, and Medi-Cal access/timeliness metrics, and report on consumer complaints and IMRs.

E. CHIS - The California Health Interview Survey (CHIS) is the largest state health survey in the nation. It is a web and telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing the survey to generate timely one-year estimates. CHIS provides representative data on all 58 counties in California and provides a detailed picture of the health and health care needs of California's large and diverse population.

When Available: Varies by Metric

Possible Metric(s): Socioeconomic and health characteristics of California adult population, delayed medical care or prescription in the past 12 months, timeliness of healthcare appointments, communication with doctor by insurance coverage, usual source of care.

F. California Insurance Affordability Program Application Data - Description: Number of individuals included on applications and the number of applications received for Insurance Affordability Programs (IAPs) from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), including applications submitted directly to CalHEERS, to Covered California, and to County Human Services Agencies through the Statewide Automated Welfare System (SAWS) eHIT interface.

When Available: Varies by Metric

G. Center for Data Insights and Innovation (CDII)/Office of the Patient Advocate (OPA) - The OPA has data about health care complaints made by California consumers to the DMHC, DHCS, California Department of Insurance, and Covered California. These reports also include information about state consumer assistance centers.

When Available: Varies by Metric

H. CAHPS - The primary purpose of the CAHPS surveys/databases are to facilitate comparisons of CAHPS survey results by and among survey users. Medi-Cal CAHPS survey data is collected annually and can be compare with the national benchmarks of different business lines to allow assessment for access gaps.

When Available: Medi-Cal CAHPS survey data is available now. DHCS will purchase MY 2022 NCQA commercial, Medicare, and Medicaid benchmarks from NCQA for comparisons with Medi-Cal in the fall of 2023.